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REPORT OF PUBLICATIONS COMMITTEE.*

Madam President and Ladies:

At the second annual meeting of the Canadian Society of Superintendents of Training Schools for Nurses, held in Ottawa, October 8th and 9th, 1908, Miss Snively, who was its first President, with her usual acumen, was mainly responsible for the inception of the Canadian National Association of Trained Nurses.

In 1899, there was formed in London, England, at the instigation of Ethel Gordon Fenwick, the International Council of Nurses (see American Journal of Nursing, Aug. 1901). This Association, originally composed of the councils of Great Britain, Germany and the United States, now includes Holland, Belgium, Finland, Norway, Sweden, Denmark, Switzerland, Italy, Canada, Australia, New Zealand, India, Cuba and Japan

Through her membership in the American Society of Superintendents of Training Schools, Miss Snively was chosen as the first honorary treasurer of the International, which office she held five years, when she was elected its vice-president.

In the United States, in 1904, the two representative nursing organizations, viz., the American Society of Superintendents of Training Schools for Nurses and the Associated Alumnae of the United States, formed themselves into the Federation of American Nurses. The united executives of these societies elected officials, and in this way gained for American nurses admission into the International Council of Nurses. It was on similar lines that Miss Snively planned the same benefits for Canadian nurses.

Previous to the meeting in 1908 at Ottawa, letters had been sent to all known nursing organizations in Canada, inviting them to affiliate with the Canadian Society of Superintendents of Training Schools for Nurses, with a view to discussing whether it were advisable and possible for Canada to unite with the International Council of Nurses that year—1908. Many societies were represented by delegation, and it was decided to form a temporary committee to be called "The Provisional Committee of the Canadian National Association of Trained

* Read at Third Annual Meeting of the Canadian National Association of Trained Nurses, Berlin, Ont., May, 1913.

Nurses. This committee was formed of delegates from fifteen societies who, with other individual members, signified their desire to form a Canadian National Council. A short provisional constitution was submitted and accepted (see report second annual convention, Canadian Society of Superintendents of Training Schools, page 4).

The following year (1909), the Association was affiliated with the International and sent delegations to London. A full account of the proceedings was published in "The Canadian Nurse," September and October, 1909, which also contains a notable portrait of the Canadians at Frogmore where they placed a wreath upon the tomb of the late Queen Victoria, (page 643). In 1912, representatives attended the meeting of the International Council at Cologne. (Report to be given at this meeting.) The next International Congress is to be held in San Francisco in 1915. So much for foreign policy.

The meetings of the Canadian National have been reported in "The Canadian Nurse," making it superfluous to describe them here, except to say that at the inaugural meeting in 1908 it was decided to meet every three years. The first meeting took place in 1911 at Niagara Falls, Ont. When the constitution was adopted and when it was decided to hold meetings yearly until things should be fully in working order. (See "The Canadian Nurse," August, 1911). A meeting was held during 1912 in Toronto. ("The Canadian Nurse, May 1912.) This meeting in Berlin is the third regular meeting.

The home policy of the Association is the union or affiliation of all Canadian nursing organizations, so that every nurse may have a voice in nursing education and interests, and incidentally in the betterment of nursing conditions throughout the Dominion.

So far, the Association comprises twenty-six affiliated societies, of which a full list is appended.

Owing to the sparse population and the scattered and remote districts in the Dominion, our nurses are peculiarly isolated as compared with that of other countries. This fact has been a deterrent in many matters of reform and progress.

The only means by which this Association can effectively work is through a national journal of nursing, owned and managed by nurses. It should guide and inform those who need guidance and information, and it should voice the opinion of nurses all over the Dominion and stimulate them to express their ideas so that the East and the West may better understand one another and that present isolated conditions may be overcome.

It is the opinion of the Publication's Committee that the best and most effectual way to attain a national journal is for each and every society and indicidual nurse to make a special and particular effort to support "The Canadian Nurse," to subscribe to it collectively

and individually, to send articles and notices and to endeavor to make it, not the local organ of the east, but the voice of the Dominion, as it is intended to be. Let each province hold itself responsible for definite contribution to the magazine. Such general effort and responsibility would not only make "The Canadian Nurse" the factor it should be in the Dominion of Canada, but would also enable the National Association to fulfil its avowed home policy.

(Signed) M. L. Lyman,
Convener.

LIST OF AFFILIATED SOCIETIES

1. Victoria Graduate Nurses' Club, Victoria, B.C.
2. Collingwood G. & M. Hospital Alumnae Association.
3. St. Catharines G. & M. Hospital Alumnae Association.
4. Montreal General Hospital Alumnae Association.
5. Toronto General Hospital Alumnae Association.
6. Riverdale Hospital Alumnae Association, Toronto.
7. Toronto Grace Hospital Alumnae Association.
8. Royal Victoria Hospital Alumnae Association, Montreal.
9. Kingston General Hospital Alumnae Association.
10. St. Michael's Hospital Alumnae Association, Toronto.
11. Vancouver Graduate Nurses' Association.
12. Canadian Nurses' Association, Montreal.
13. Manitoba Graduate Nurses' Association.
14. The Graduate Nurses' Association of Ontario.
15. Canadian Society of Superintendents of Training Schools for Nurses.
16. Thunder Bay Graduate Nurses' Association.
17. Calgary Graduate Nurses' Association.
18. The Alumnae Association, of Victoria Hospital, London.
19. Nichol's Hospital Alumnae Association, Peterborough.
20. Hamilton City Hospital Alumnae Association.
21. Toronto Western Hospital Alumnae Association.
22. Ottawa Graduate Nurses' Association.
23. Galt Hospital Alumnae Association.
24. Hospital for Sick Children Alumnae Association, Toronto.
25. Edmonton Graduate Nurses' Association.
26. The Graduate Nurses' Association of Berlin and Waterloo.

LIST OF INDIVIDUAL MEMBERS

Misses Brent, Rogers, Crosby, Stewart, Phillips, Christie, French, Mathieson, H. Stewart, A. Andrews, Green, Miller, A. Scott, Stanley, Madden, Snively, Green, McFarline, Mackenzie, Wilson, Dixon, Shaw, Brown, Mrs Reynolds, Bowman, Fournier.

THE VALUE OF NURSING ORGANIZATION TO THE PRIVATE NURSE

By Mrs. A. H. Paffard, Toronto

Madam President and Ladies:

Through your courtesy I have been asked to contribute a paper on "The Value of Nursing Organizations to the Private Nurse," and your invitation kindly concluded with the libel that "your experience in private nursing was so great that you are best fitted to contribute this paper." Now, in mere justice to the subject and to the many graduate nurses who have done much longer service in private practice than the speaker, let me say that neither my few years of private nursing nor the subsequent interest that I have taken in nursing organizations have qualified me to handle this subject in a way which its importance deserves. When I look back—and the years cannot be counted on the fingers of both hands—to the period of my private nursing, I am still further convinced that your Executive have made an unwise selection in the contributor of this paper, because they have asked one to give an opinion on a subject of which, unfortunately, she did not have the advantage of a personal experience. In my day, or rather days and nights of private nursing, organizations of nurses in Canada were only in their incipiency, and my own Alumnae Association was barely out of its leading strings. Therefore you must permit me to treat this subject largely from the observations that my subsequent connection and close touch with nurses' organizations and many individual nurses will enable me to make.

I was about to say that the value of nursing organizations to the private nurse must be so palpable that it would be almost superfluous to attempt to discuss it. On the other hand it immediately comes to mind that this value must be either debatable or not thoroughly understood and appreciated, otherwise our present organizations would receive much better support from the great body of graduate nurses in private practice. I cannot admit that it is debatable, on the contrary I look upon it as an educational question—and in this respect our Superintendents of Training Schools can do much to influence the young graduate to affiliate herself with her own Alumae and her provincial association. Speaking as a past officer of my own Alumae and in my connection with the Graduate Nurses' Association of Ontario, I can assure you that the education of the graduate to the importance of supporting nurses' organizations must be imparted prior to or immediately after graduation, otherwise she soon drifts apart and is extremely difficult to reach and to interest.

Before preparing my paper I was fortunate enough to receive

*Read at Third Annual Meeting of the Canadian National Association of Trained Nurses Berlin, Ont., May, 1913.

the April number of "The Canadian Nurse," and its editorial on "Amalgamation"—which I trust you have all read—sets forth much more effectively than I can the proper relation and reciprocal advantages to the nurse, her Alumae Association, her Provincial Association and the National Association.

The function of an Alumae Association is more particularly to keep its members in close professional and social touch with one another, to maintain an "esprit de corps"—which latter means so much to those in training and the welfare of the school—to promote lectures for the benfit of older graduates on advanced methods in medicine and surgery, to interest members in social service and kindred work, to assist in the establishing and the proper conducting of registries, the protection of its members against imposition, both pro-

Berlin and Waterloo Hospital, Berlin, Ont.

fessional and financial, and by frequent contact, social and otherwise, exercise a healthy broadening influence on the individual nurse, which after all is one of the best guarantees of the maintenance of professional standing. I think that it cannot but be admitted that these features are of inestimable value to the nurse in private practice.

And let us not overlook the obligations resting upon the Alumnae Association to enjoin its members to give their support to their Provincial Association, through which can only come, under present political conditions that legal recognition and protection of nursing as a profession, for which we have been striving and will continue to strive.

While I do not believe in a multiplicity of organizations, and am sometimes forced to the opinion that women are perhaps prone to divide their effective strength through this mistake, yet there cannot

be any doubt that our Alumnae Associations, the Graduate Nurses' Association of Ontario and our Canadian National Association each has its proper functions and each, by proper co-operation, can assist in the betterment, not only of the profession as such, but of the individual nurse and the conditions under which she works. And right here let me inject—does the individual nurse realize that? If she did thoroughly I venture to say that our attendance here to-day would be many times larger than it is. A full realization of the benefits accruing would develop, not merely a passive membership, but a strong, vigorous, active support. Gratifying as our progress has been through the untiring efforts of a few, we need especially a better distribution of this enthusiasm and a larger interest from the many. As I have already intimated, the entire movement is an educational matter.

Having dealt with Alumnae Associations permit me to briefly point out the work being undertaken by the Graduate Nurses' Association of Ontario—work that in my opinion is of vital interest and value to the welfare of the private nurse. I need hardly refer to our efforts, only temporarily suspended, to secure legislation that would directly protect the private nurse from imposters and would equally protect the public, and would bring about an elevated and uniform standard of training. A legal recognition of nursing as a profession would unquestionably secure to us, in a measure at least, some of the protection enjoyed by the medical profession, the public would be protected from the "quacks" of both professions.

For some time past the Executive of the Graduate Nurses' Association of Ontario has had under serious consideration and are taking steps to combat the growing evil in Canada of short term and correspondence schools. These schools are becoming rather aggressive, and their advertising propaganda is deceiving many otherwise desirable probationers into taking up their so-called course of training. To one who knows—as you all do—what qualifications are essential and how only those qualifications can be obtained by a really "trained nurse," the thing would be positively ridiculous were it not for the serious dangers accruing to both the profession and the public, especially to the latter. These are matters that can only be dealt with by a large organization with provincial scope and influence, and I would plead for the support of every graduate nurse, whether a member of her Alumnae or not, by affiliating herself with the Graduate Nurses' Association of Ontario, through which organization can only be effected those measures of protection that I have briefly outlined.

Progressing then to the broader field we have your organization: the Canadian National Association, which I observe from Article I, clause 2, of your Constitution is almost international in character.

The objects of your Association as set forth are in many respects parallel with those of our Provincial and several Alumnae Associations, and this very unity of purpose augurs well for the ultimate success of the movement. Unquestionably your Association can do a great deal to elevate and unify the standard of training in Canada and bring it to the highest point of efficiency in all respects—if we have not quite attained that desirable position.

In conclusion I would appeal to the individual nurse, isolated though she may be, absorbed in the exactions of her daily task, out of touch with her sisters in the profession, to you, Nurse, I would say, lend us a hand and let us lend you a hand, for in union only is strength, and we each need the other's help.

To the nurse, perhaps more fortunately situated by closer touch with her fellow-graduates, with a better vision of the problems that confront the profession and how these may be solved, I urge her added responsibility of bringing her isolated sister within the membership of her provincial Association.

To the Superintendents of Training Schools, I particularly plead for the education of undergraduates to the importance of their joining and actively supporting both their Alumnae and their Provincial Associations.

To you, Madam President, and your Executive, I feel that I need hardly bespeak for our Alumae and Provincial Associations the hearty support and co-operation of the Canadian National Association, which I can assure you will find reciprocal response in the great common cause for which we are all working.

TUBERCULOSIS IN CHILDREN.

We here reproduce from *The British Journal of Nursing* a very interesting and instructive paper on this important subject by Dr. A. Knyvett Gordon:—

"I have chosen the subject of tuberculosis as it affects children for two reasons: firstly, because it is not very easy for a nurse to get a clear idea of the subject from the average text-book of medicine, where she will probably have to wade through a large quantity of facts and figures only to find, after all, that they relate mainly to pulmonary consumption in adults—a very different thing.

Then I know of no disease which so well illustrates the way in which the body reacts to an attack made on it by micro-organisms, and I always think that if a nurse has in her head a clear idea of the nature of the fight which is constantly going on between ourselves and these our invisible enemies, she is much less likely to think of the care of her patients as drudgery—everything, incidentally, which we do not under-

stand, but yet have to do, must be either drudgery or a meaningless ritual.

So I am going to begin with the tubercle bacillus itself, and then show how it affects the children who are exposed to its attacks. As usual, I shall leave out very much in order that the main outlines of the picture may be clear.

The tubercle bacillus is an organism that has a great power of living under adverse circumstances; in particular, it may lie in a dried-up state for a long time, but so soon as it reaches a supply of moisture and food, it emerges from its inactivity and grows with vigour in its new surroundings. It is also rather hard to kill, a fairly prolonged contact with quite strong solutions of disinfectants being required for this purpose. Some of the so-called antiseptics it has no objection to whatever, as it will even grow after it has been treated with a solution of them. Though this is rather a digression, I may say that it is very much to be wished that some law could be passed making it illegal to publish false descriptions of disinfectants. Many poor people spend shillings which they can ill spare on preparations which merely smell, and which do not give the much-advertised protection from disease which causes them to have so ready a sale; they may subsequently pay the penalty for their quite excusable faith in the loss of one of their children from the ravages of an organism which has been liberally attacked according to the directions on the bottle.

Now the tubercle bacillus attacks cattle as well as human beings, so that the two main sources of bacilli which can infect children are dust containing dried-up bacilli from the expectoration of persons whose lungs are affected by the disease, and milk from infected cows. These latter often suffer from tuberculosis of the udder, even though they appear to be pretty well in themselves, and take their food well. Many cow keepers therefore do not know when they have such animals in their possession, and, as the reports of inspections of farms show, some do not mind mixing milk from cows that they know to be thus diseased with the common stock. It was formerly believed, on the dictum of a celebrated bacteriologist, that bacilli from cows could not give rise to tuberculosis in human beings, but this assertion has now been shown to be erroneous—in fact, the possibility of bovine infection has been proved up to the hilt by the deaths of thousands of small children—a veritable massacre of the innocents.

Tuberculous milk, however, is not the chief source of infection in children, though it is, or should be, the most easily preventable. In a large series of fatal cases it was found that the organism had entered by the lungs in 63.8 per cent., by the ear in 6 per cent., and by the intestine in 29 per cent. In rather less than one-third, therefore, was the

milk to blame, and infected dust must be held responsible for the remaining two-thirds—it is probable that the ultimate source of this in almost every case is the dried-up expectoration from adults with phthisis, or "consumption," as it is popularly callde. Hence the "prevention of spitting" notices in public places.

As regards the frequency of the disease, statistics of post-mortem examinations show that about one-third of the children who die in hospitals do so on account of tuberculosis in one form or other, and in a further 12 per cent. signs of tubercle are found, though this has not been the actual cause of death. This is rather an appalling state of things when we consider that the sources of infection are known and preventable.

Now in childhood the tubercle bacillus attacks the blood-forming organs. We know from the researches of physiologists that the red corpuscles of the blood are manufactured in the red marrow of the bones, and the white cells in the lymphatic glands which are situated all over the body. Now we have seen that in the majority of cases the bacilli are inhaled in infected dust. In healthy children the glands which serve the bronchi, or tubes down which the dust is drawn in the process of inspiration, are able to deal with the bacilli and destroy them; each gland contains a large number of white blood corpuscles which are the policemen of the body in the sense that they arrest and withdraw from the community such criminals as micro-organisms. Consequently nothing more is heard of the tubercle bacilli in the case of the thousands of healthy children who are daily inhaling tubercle germs.

But let us suppose that these glands are not very healthy themselves. Instead of the white cells destroying the bacilli, these latter destroy the corpuscles, and the germs are thus able to enter the general blood stream, whence they are carried, amongst other places, to the bones and joints, or it may be to almost all the internal organs simultaneously, when we get the disease known as general (or miliary) tuberculosis. The commonest cause of this weakening of the bronchial glands is a previous attack of bronchitis from measles or whooping cough. Similarly, when infected milk is swallowed, the mesenteric glands which serve the intestine should stop the invaders; but if they do not they become filled with bacilli themselves, and so these organisms are enabled to reach any part of the body through the blood stream. Perhaps the commonest cause of weak intestinal glands is digestive trouble (diarrhœa and so on) from improper feeding of the child on "what we has ourselves."

Whether the bacillus enters in dust through the lungs or ear, or in infected milk through the intestine, there is a great tendency for the disease to spread through the various organs of the body, and this is much more likely to happen in children than in adults, and, strange

though it may seem, there are often very few symptoms, even when the general invasion is extensive, and the reason is that the child, as a rule, dies before the little patches of tubercle grems have had time to break down into abscesses, when they would give rise to discoverable signs. Consequently we have to rely on certain general, and often rather indefinite, symptoms, and the diagnosis is often very difficult; indeed, I have seen, post-mortem, all the internal organs of the body riddled with little patches of tubercle in a case where most careful clinical examination failed to discover any definite sign of that disease, though its existence was, of course, suspected. And it must be remembered that children, as a rule, do not expectorate, so we cannot examine their sputum under the microscope for the presence of tubercle bacilli, as we can in adults. The first of these general signs is irregular pyrexia, without anything to account for the rise of temperature. When this is combined with wasting we should always suspect the existence of disseminated—that is, spreading—tuberculosis. Or we may not get even a rise of temperature at the commencement of the illness, but only apparent illness, or fretfulness without any discoverable sign of gross disease on careful and exhaustive clinical examination.

Recently, however, some help has been obtained from the discovery of the fact that if we scratch the skin of a child, and then rub in some dead tubercle bacilli or else put a few of these into the eye, nothing happens if the child be not tuberculous; but if he is, inflammation will appear round the site of the scratches, or a slight redness of the conjunctiva if the eye has been selected, and we are often able by this means to detect tubercle in quite an early stage, when it may be sometimes possible to cure the patient.

Another valuable sign is the investigation of what is known as the opsonic index for tubercle. In this process a little blood is taken from the finger and mixed with some dead tubercle germs in a small tube, which is then placed in an incubator for twenty-four hours. A drop of the mixture is then examined under the microscope, and the number of the patient's white cells which have tubercle bacilli inside them—showing that the corpuscles have made an attempt to swallow the bacilli—is compared with the result of a similar drop from a mixture of bacilli and the blood of a healthy person. If the patient's corpuscles have fewer bacilli inside them than those from the healthy person, it shows that he is in all probability tuberculous.

But we have seen that the glands at the root of the lung—the bronchial glands— and in the abdomen—the mesenteric glands—are very likely to be attacked, so we have to see if we can recognize the presence of tubercle in these.

In the case of the bronchial glands we can suspect disease when the

child has a frequent spasmodic cough, and, as a matter of fact, when a child has an attack of whooping cough which does not clear up, we should always suspect that tuberculosis of the bronchial glands may have supervened. There are other signs also which are rather too intricate to be described here, but in practice we do not often succeed in detecting this trouble until one of the glands has broken down into an abscess which has burst into the lung and has given rise to tubercular inflammation there also.

In the case of the abdomen the outlook is not so hopeless, because the signs are easier to detect, and, moreover, abdominal tuberculosis is much more easily curable in children than tubercle of the lung.

In practice we detect tuberculosis of the abdominal glands by the spreading that almost always takes place into the surrounding peritoneum, which becomes hard and matted together in masses, or there may be free fluid in the abdominal cavity; both the lumps and the fluid can be easily felt when the abdomen is handled. The condition is known as tubercular peritonitis, or, as it used to be called, "tabes mesenterica," and is a very common form of tubercular disease in children.

We have also seen that in some cases the germs enter through the middle ear. Probably the immediate source of this is settling of infected dust in the external ear passage, but if the ear itself be intact, it is very doubtful whether much harm is done as a rule. But the case is different when the dust finds a hole in the drumhead leading into an ear which is the subject of chronic discharge, generally from a previous attack of scarlet fever or measles. Then the tubercle bacillus finds soil in which it can grow and multiply, and sooner or later the trouble spreads from the ear into the closely adjoining covering of the brain, and we have inflammation of the meninges—tubercular meningitis—or disease of the brain itself—tubercular tumour or cerebral abscess.

It is not always, however, in this way that the brain or its membranes become infected. They may be attacked by germs from a tubercular bronchial gland, or from enlarged tonsils or adenoids, or the bacilli may reach the brain through the nose. In any case, unless the surgeon can successfully intervene before the organisms reach the inside of the skull, death almost always results.

But tubercle need not necessarily be a "medical" disease. We may have the various forms of so-called "surgical" tuberculosis, and this simply means that tubercle has attacked either lymphatic glands or bones in regions that are within the reach of the surgeon. One very common form of this is the enlargement of the glands of the neck; if these are not dealt with in the early stage they may break down into abscesses which discharge through the skin, leaving a track or sinus leading from the skin to the gland, which is perpetually discharging,

healing up, and discharging again, until the system becomes infected, and we then get either general tuberculosis or involvement of the lungs, abdomen, or brain as before.

Or some bone may be attacked. Here, though we may get almost any bone affected, two forms are most common, namely, disease of the hip-joint and of the spine, and it is these two between them that are responsible for the pathetic procession of crippled children who pass from one general hospital to another, having often to be discharged before they are cured, owing to lack of room, until they ultimately reach a workhouse infirmary, unless, indeed, they are fortunate enough to secure scientific treatment in pure air in such an institution as the Treloar Home.

I do not now propose to describe these two diseases in detail, but I may mention that hip disease shows itself first in pain (which is often agonizing) in the hip and knee, the nin fixation of the joint in such a position as to cause a limp, and, finally, in the breaking down of the inflamed bone into an abscess which discharges through one or more channels in the skin round the joint—a perpetually running sore.

In disease of the spine we get at first pain in various regions, according to the situation of the disease, and then an abscess which discharges in the groin—psoas abscess—and if death does not—shall we say fortunately?—previously ensue, the deformity that we know as hunchback.

Before going on to the treatment of tuberculosis in children, which will form the subject of the next paper, I may sum up the course of the disease. The germ gets in generally through infected dust or through infected milk. It reaches the bronchial glands, and goes on to kill the patient by infection of the lungs or brain, or the abdominal glands, proceeding thence to attack the peritoneum and intestine; or it attacks the ear and thence the brain or its membranes; or it seizes on external glands, or on bones with the resulting crippling deformities. But by whatever path it enters, unless its progress can be arrested, the end is ultimately death from generalized tuberculosis. Considering the life that a tubercular child in poor environment has to lead, we may perhaps be pardoned if we sometimes think that the sooner this comes the better."

WORK IN A MINING CAMP.*

By Beatrice Dougherty.

I have the honour of being requested by your Association to write a paper on our work in a mining camp, so I shall endeavour to tell you briefly what I found to be everyday life.

To begin with we will try to locate our camp, perhaps making it slightly more interesting.

As everyone is undoubtedly familiar with our Canadian prairies, we will board the Crow's Nest train at Medicine Hat, just the gateway from the fertile rolling prairies to the majestic Rockies and the home of the celebrated Alberta wheat and vast cattle ranges. We go through a flat country, broken in places by gulches, for somewhere in the neighbourhood of one hundred and ten miles. Then we reach Lethbridge, Alberta's most prosperous mining town. The output of the mines find a ready market in Montana and British Columbia principally. After leaving Lethbridge we pass through rolling plains for a distance of almost thirty miles, then we come to McLeod, where mixed farming is a most profitable industry within a radius of forty miles, climatic conditions being most favourable for such. Now we really leave the home of the cattle kind and cowboys and enter the gorgeous Rockies. The Rockies are parallel for a short distance, affording magnificent views of their marvellous proportions.

Victoria Peak, height 9,860 feet, and Castle Mount, are prominent in the distance; to the south—by the way, we are travelling west—Turtle Mount is seen in front of us, shaping itself into a huge tortoise, silhouetted against the sky.

There is indeed a glorious panorama spread before us behind vast plains which stretch away till earth and sky become one; in front the serrated Rockies standing forth in all their sublimity and grandeur piercing the very clouds.

It might be of interest to add that it was a part of Turtle Mt. which buried the town of Frank in April of 1903, and the mountain is now deemed dangerous, according to the decision made by a party commissioned by the Government to make investigations. At this town a peak looms to a very great height, its base forming one of the walls of the gap in the Crow's Nest Pass, and here a last view of the grand old "Crow" is obtained before leaving the Pass. Some few miles west we reach the summit and the historical Crow's Nest Lake, where Ralph Conner lays the plot of one of his many beautiful and interesting stories.

The remains of the original camp are still to be seen. This lake is credited with being the birthplace of the zephyrs that blow across the

*Read before the Women's Local Council, Winnipeg.

plains, and it is known that on occasions when the western part of the lake is calm and still, white caps predominate on the eastern. The source of this lake is the outflow of a subterranean stream, which flows from the "Cave," an outlet in the side of Mount Sentinel.

Now we are in our camp, which enjoys an ideal climate and an altitude of five thousand feet above sea level. To the east we have Turtle Mountain; north, the "Crow"; south, the Livingstones. There is a beautiful old legend about the "Crow," but I must not take time to tell you now.

Large and small hospitals are scattered throughout the Province and are indispensable, but from financial obstacles they lack modern equipment. Efficiency can only be attained by increasing expenditure. Hospitals are ot dividend-paying concerns, and this, combined with lack of information concerning the great need for such, has much to do with failure to attain public support. It certainly presents a splendid opportunity for philanthropic work. As in any camp, our work is purely emergency. The miners' local Union, to the best of its ability, has built and equipped a very nice little cottage hospital for the injured, which could, if necessary, accommodate fifteen patients.

We have the usual drawbacks to contend with in any Western Canada hospital, the cause already stated. As a rule homes are small and when possible the patient is sent to the hospital. In one small public ward medical and surgical cases lie side by side with infectious ones, conditions regarded with awe by some of our co-workers accustomed to other methods before coming to the wild West.

When this hospital was opened some six or seven years ago the town was in its infancy; conditions were such that a fully qualified nurse was not available and the necessity of one was not realized. As time went on the mines enlarged, more men were employed, and consequently a greater percentage of accidents. The company realized the necessity of a modern surgeon with modern methods. When he arrived, conditions were appalling. As I had received training in the same hospital, he wrote asking me to go out and help him. I went and found four patients, all badly in need of care. Empty beds were converted into general "catch alls" and seating accommodation for visitors; rubber sheeting was unknown; grey blankets and sheets were in use and far from being sanitary. Night gowns were replaced by discarded night shirts and underwear. Patients existed as in cells, because they knew of no other treatment. Towels and blankets were unhemmed and amazingly few in number. Pillows and mattresses were so stained we had to discard them entirely, as we could have them replaced. Baths were an unknown luxury; one patient left after first bath, because he never was bathed before, or as he said, "He never was treated so before."

Kitchen utensils were used alike for cooking and dressings. An operating room was unknown, bath rooms serving for minor surgery, and nature did the rest.

The wards were at the best nothing better than a very poor boarding house; we had four walls and nothing else pertaining to an hospital. Well, I did not have time for a good, old-fashioned cry, just where to start I did not know. By a previous statement you know there were four patients; one left first day for reasons stated; he had a fractured humerus done up in a loose gauze bandage. No. 2 was a convalescing pleuro-pneumonia, who was in a corner, covered with filthy bed clothes, I cannot say linen; windows were nailed down to prevent a draught. No. 3, a typhoid running a temperature of 106, his fifth day after admission, and still dressed in his woolen underwear—a Russian unable to speak one word of English, and delirious. To prevent him from contracting cold he was covered with a double pair of grey blankets, and it was a sultry Indian summer day the first week in October. No. 4 had a fractured jaw, in his seventh week after admission, reeking with pus, coal dust, various foreign materials and creatures were still lodged in his hair, ears and underwear, all combined with clots of coagulated blood, from date of accident.

I moved the pneumonia patient to a room where plenty of oxygen was obtainable. Took sapolio, turpentine and a brush and made the typhoid as comfortable as conditions would permit. With the kindly assistance of our Surgeon Chief, the head of our fractured jaw case was shaved. Baths were given on the installment plan for obvious reasons. The hospital was full of patients inside one week.

With this additional work improvements were made as time would permit. First we had a proper housecleaning period, ex-patient's clothes were collected in heaps on the gravel floor of a woodshed, the odour of rank machine oil and mould was not at all appreciated. By degrees we got some of the much needed linen, and, to save expense, I hemmed it myself as I found time for so doing. Then I tried to fit up a little operating room. In one month's time we had sufficient utensils, towels, sheets, gowns, caps, masks, sponges, dressings, etc., to do our first major operation—a gastroenterostmy, canastomosis and appendectory on one patient—and a comfortably furnished private room to put him in. To our extreme delight the incision healed by first intention and our patient went home on the tenth day.

With the kindly assistance of a friend and the use of her sewing machine, many an evening we have made supplies till midnight and then I did most of my sterilizing, because at that time the range was not in use. I improvised a sterilizer, by using an ordinary steamer over a pot of boiling water, and dried articles sterilized in the oven. Eventu-

ally we got an Arnold Sterilizer. We had a cabinet similar to a chiffonier and about four feet in height made by the village cabinet maker and fitted with various sized drawers for surgical supplies. As this gave us a flat top, we had two twenty gallon copper boilers fitted with taps made by the tinsmith and converted into hot and cold water sterilizers and set on the top of the surgical supply cabinet. A small kidney-shaped table was also added, which we used for instruments during an operation. I bought white enamel paint and practised in our operating room, and now I'm a painter.

Our doctor bought glass shelves and fitted up an instrument cabinet out of top of a home-made cupboard. Fortunately we had the town light and water works. As we went along we added the necessary requisites, endeavouring to equalize our monthly expenditures. I had considerable difficulty in convincing the Hospital Board—composed of miners and labourers—that the increased expenditure was absolutely necessary in order to obtain good results. During the year I was there we had sixty major operations, and never a single pus case developed from a clean one. Of course it meant never-ending precaution, work, and constant fumigating. When I went there one graduate nurse was considered an unnecessary luxury. I was there on approbation for a year. When the agreement was drawn up between the local Union and their doctor, after the prolonged strike, a by-law in the new constitution demanded two graduate nurses and one orderly on the staff permanently.

A new forty-bed hospital is now under discussion, which, if it materializes, will in all probability be a municipal one, open for donations, private subscriptions and assistance from benevolent societies. The chief requisites are linen of every description, and reading material, which is graciously received by every class. Such employment does away with unnecessary chatter in a public ward and is pleasant as well as a profitable pastime.

I found that Benefit Societies, in connection with the churches, had as much as they could manage when providing for children in their respective congregations. Of course I was there during a prolonged strike, an exceptionally trying time for all.

Now, my talk has been much longer than I anticipated, and I humbly apologize; my only plea being that there seems to be so very many things to tell in connection with our work, so much to be done, and so few to do it. Not because those closely connected are unwilling to assist, but for want of knowledge to do the right thing at the right time, in the right way.

The camps are composed largely of the foreign element, and so many factions, and hospital work unknown to all of them. The most difficult task is to show them something "big" and quick for their

money. If this is achieved their co-operation is freely given, and, what is better still, their financial support. But first and foremost they must be educated to the fact that these requirements are a necessity.

The work is extremely interesting and presents a very large field for philanthropic work, and in the very near future I hope to be with them again. The work was so strenuous I found it necessary to make a change for a time.

Trusting this may offer you a few suggestions from which you may receive some knowledge to aid in your noble and far-reaching work.

MURPHY'S METHOD OF ADMINISTERING SALINE SOLUTION PER RECTUM.

The necessity of supplying a liberal amount of fluid as a post-operative treatment, particularly for septic cases and as a restorative in cases of collapse from loss of blood or other causes, has long been recognized by physicians.

In the majority of such cases the fluid must be administered by bowel, and the skill of the nurse in administering it is an all-important factor in the results obtained.

In a lecture on this subject delivered to the nurses of the North Friary Nursing Home of Plymouth, and printed in the *Nursing Times*, Dr. C. Hamilton Whiteford says that in health, of food taken by mouth, very little of the watery part is absorbed until the food reaches the large intestine. In other words, man eats with his small intestine, but drinks with his large bowel. Saline solution, run slowly into the rectum, is carried back into the colon, from which it is absorbed. The large intestine will not absorb more than the patient requires, and thus makes it impossible for the patient to take up more fluid than is good for him.

It is these facts which enabled Dr. John B. Murphy, of Chicago, to work out his system of administering large quantities of saline solution per rectum, a method of treatment which has saved many lives during recent years.

It is at least six years since Murphy worked out his method, but it is the exception to meet with a nurse who can give saline solution in such a way that it will be absorbed in large quantities; and it is quite common to meet with medical men whose knowledge of Murphy's method is either non-existent or so faulty as to be useless. Murphy himself says: "We have visited hospitals numbers of times, and have been shown patients who were receiving the 'Murphy treatment.' We should not have recognized it without the label."

The essential principle in administering the saline solution is described by Murphy thus: "The flow must be controlled by gravity alone, and never by a forceps or constriction on the tube, so that when the

patient endeavours to void flatus or strain, the fluid can rapidly flow back into the can, otherwise it will be discharged into the bed. It is this ease of flow to and from the bowel that insures against over-distension and expulsion on to the linen." He also says: "When the nurse complains that the solution is not being retained, it is certain it is not being properly given."

The surgeon being unable to attend hour after hour to supervise personally the giving of the saline solution, the fate of the patient, and possibly the reputation of the surgeon, are, for the time being, absolutely in the hands of the nurse. There have been many attempts to modify Murphy's method, those alone are successful which include the principle of free communication between the reservoir and rectum, the rate of flow being regulated solely by the height of the reservoir above the end of the rectal tube.

SALINE SOLUTION.—Strength, 1½ drachms of sodium chloride (common salt) to each pint of warm water. The temperature of the solution in the reservoir is 105 degrees F., taken by thermometer, never guessed at. The temperature of the solution when it reaches the rectum after slowly running through the rubber tubing will be about 100 degrees F.

APPARATUS.—The simplest form consists of a douche can with five feet of rubber tubing, stout walled to prevent kinking, and of a diameter (inside measurement) of three-eighths inch, ending in a metal or rubber nozzle, in the end of which are several openings.

RESERVOIR.—Of this there are several forms.

1. The ordinary douche can, which is wrapped in several layers of flannel to retain the heat.

2. Moynihan's glass bottle, which has a wide bottom, and from which the solution runs by syphonage. This bottle is placed in a bowl of warm water, the bowl resting on a stand above a spirit lamp to prevent undue cooling.

3. A rubber bag, covered with blanket, in the same manner as the douche can.

4. A can which is kept warm by electricity (Paterson's). Dr. Ellbrecht uses, in addition to the reservoir, a small metal cylinder warmed by either a spirit lamp or by electricity. The solution flows from the reservoir through this warm cylinder before it passes on towards the rectum.

5. A Thermos flask, either inverted or discharging by syphonage. The reservoir is either (1) hung on a rail of the bed, or (2) on a special stand which can be either raised or lowered.

RECTAL TUBE.—(*a*) Of flexible metal; (*b*) of stout rubber; (*c*) a self-retaining bulb, made of vulcanite, shaped like an acorn, with a central lumen from which projects the end of a small œsophageal tube.

Both (*a*) and (*b*) end in a bulb. A jaques or self-retaining No. 12 rubber catheter is best. The metal tube must be bent three inches from its bulb, to nearly a right angle, to prevent the point from causing pain by pressing against the posterior wall of the rectum. The rubber nozzle and catheter being flexible, adapt themselves to the shape of the rectum, the pressure of their ends being slight. The rubber nozzles are preferable to the metal tube, because they cause less discomfort. The patient's discomfort is minimized if the rectal tube is inserted before he comes out of the anæsthetic.

Position of the Patient.—The patient is usually in the "Fowler position," i.e., semi-erect, the back against a bed-rest. He is prevented from sliding down in the bed by a firm pillow under the thighs. This pillow is two feet in length and one foot in width. Many pillows are made too wide. The border of the part nearest the buttocks has a semicircle cut out of it to allow access to the rectum. It is covered with mackintosh, between which and the patient's skin is placed a towel. Straps pass from each end of the pillow to the head of the bed, the straps being attached to the bed-rails on a level with the shoulders. The patient is thus supported as on the seat of a swing, but the seat (i.e., the pillow) rests not against the buttocks, but against the thighs in front of the buttocks. The soles of the feet are supported on an ordinary pillow. The double inclined plane, made of wood, which is sometimes used to prevent the patient from slipping down in bed, is most uncomfortable, and does not allow access to the rectum.

Administration.—The reservoir, filled with 1½ pints of warm solution, is fixed at such a height that the surface of the solution is six inches above the level of the patient's anus. The nozzle is held at the level which it will occupy when inserted in the rectum, and the saline allowed to flow until it runs out of the nozzle. If the saline spurts out, instead of just dribbling, the reservoir is too high, and must be lowered until the saline just dribbles out. The rubber tubing lies on the sheet which covers the mattress, passing under the patient's thigh, and must not be compressed or kinked. The rubber tubing, where it passes from the reservoir to the bed, must not dip below the top of the mattress.

The rubber tubing is compressed between the finger and thumb, while the nozzle is being inserted into the rectum for a distance of three inches. The nozzle is retained in position by being fixed to the thigh with strapping, and by a large pad of absorbent cotton wool, which is packed against the anus. This pad of wool also helps to save the linen, if any of the saline should escape through the anus. If the reservoir is not graduated, a mark—a piece of strapping will do—is placed on

the reservoir to indicate the upper surface of the solution at the commencement of the administration.

As the solution gradually flows out, reservoir must be fixed one to two inches higher than it was at the commencement. If the solution runs out of the anus or the patient complains of feeling blown out or of wanting to empty the rectum, the reservoir is too high, and must be lowered one to two inches.

This regulation of the rate of flow is the difficult part of the administration, and can only be accomplished by practice. Beginners nearly always commence by running the solution too fast. One and one-half pints of solution should be ru nin during the first hour. During the second hour the bowel is rested, nothing being run in. In the third hour one and one-half pints are given, and the bowel rested during the fourth hour, and so on. In children one-half to one pint in the hour will suffice. The absorbent powers of patients vary greatly, some will absorb as much as two pints in the hour, but in adults nothing less than one pint in the hour (i.e., at the rate of twelve pints in the twenty-four hours) should be considered satisfactory.

During the hour when the solution is entering the rectum the flow will not be continuous, but will stop for intervals of some minutes and then start again. If the patient strains, some of the solution, often coloured by fæces, will be passed back into the reservoir, into which flatus will also bubble. The discoloured solution should only be replaced by fresh solution if grossly contaminated. The nozzle is not interfered with during the hour when the solution is not running, but is left in the rectum.

When commencing the second, third, etc., 1½ pints, it may be advisable to steady the nozzle with one hand, and with the other hand to compress the tubing where it joins the nozzle, and milk the tubing towards the reservoir, in order to displace any air which may be in the tubing, and which may interfere with the flow of the solution. After emergency operations, when the patient has not been prepared by preliminary emptying of the lower bowel, if the rectum is found loaded, an ordinary wash-out enema should be given before commencing the administration of saline. It is in these patients who have not been prepared for operation that the perforations in the nozzle become blocked by fæces. If there is any doubt as to the potency of the nozzles, it should be removed, irrigated through, and reinserted. The nozzle must also be removed prior to defæcation.

Remember that absorption of large quantities of saline solution causes a copious excretion of urine, necessitating emptying of the bladder, either naturally or by catheter, every three or four hours.—*Pacific Coast Journal of Nursing.*

GLEANINGS.

THE DIETETIC AND GENERAL MANAGEMENT OF TYPHOID FEVER IN CHILDREN:—Dr. Charles Gilmore Kerley said that there was both a science and an art in the feeding of children, whether well or ill. The child required food of definite nutritional value in an assimilable form; this was the science of feeding. It required variety and that the food selected to be agreeable to the senses of the patient; this was the art of feeding. There was no ready-made diet in any illness in a child any more than there is a ready-made diet for the artificial feeding of infants with digestive derangements. At the onset of every illness milk should be discontinued as well as all solid foods, for the reason that in every illness the child's capacity for food was lessened. It was Dr. Kerley's custom to give a laxative sufficient to produce several watery movements. The child was put on a temporary diet consisting of gruels flavoured and perhaps one of the dried milk products, until the nature of the illness was determined. In typhoid fever the diagnosis was rarely made under a week of observation, and when it was definitely settled, the intestines under this regime were free from distension with gas and undigested milk and the patient was less toxic and had a lower temperature than would have been the case had a freer feeding been permitted. It was a mistake to think that the diet they began with must be continued throughout the attack. Food would be tolerated during the latter part of the illness that could not have been taken earlier. Feedings were never given oftener than at three-hour intervals. A diet schedule for a patient five years of age would be something as follows:—

6 a.m.—Eight ounces of gruel with sugar in small amount or broth added. Zwieback or dried bread and butter.

8 a.m.—A drink of weak tea with sugar or whites of one or two eggs with sugar in orange juice.

10 a.m.—Farina, cream of wheat, rice, served with butter, and sugar or maple syrup and butter. Drink of weak tea or kumyss or matzoon, or a little dried milk food, such as malted milk or Nestle's food.

2 p.m.—Eight ounces kumyss matzoon, or skimmed milk diluted with gruel. Zwieback or dried bread and butter.

4 p.m.—Orange egg sherbet or a drink of lemonade or tea and sugar.

6 p.m.—Cereal or gruel with sugar and butter or with broth. If skimmed milk was not given at 2 o'clock it might be given with gruel at this time.

10 p.m.—Gruel with sugar or broth or with wine.

This would easily satisfy the caloric requirements of a child of five years, though the diet was not an evenly balanced one, being high in carbohydrates and low in proteids. Fat in considerable qauntities was poorly digested by young typhoid fever patients. Proteid in consider-

able quantities should not be given until something was known of the course of the disease. Milk, scraped rare beef and soft boiled eggs were not well borne in young typhoid fever patients. Carbohydrates were readily cared for when properly prepared and administered. Dr. Kerley did not advocate a milk diet in typhoid fever. The mixed feeding was not employed more generally for the reason that physicians failed to realize that other food stuffs might be taken care of easier than milk, and because of the fear of lay criticism for departing from an established custom. His favourable experience in intestinal disease with a diet other than milk, together with the teaching of Dr. A. Seibert, led him to use similar diet in typhoid fever patients. His observation had been that milk-fed cases suffered from more severe illness, increasing the danger to live; that the duration of the illness was longer; that emaciation was much greater, and that convalescence was more protracted than cases fed as had been outlined. He had learned that in order to have a short, mild case the abdomen must be kept flat; tympanities was an indication of danger, no matter how produced. On the mixed diet suggested it occurred only exceptionally. Drugs were of no service except to produce an evacuation of the bowels when there were not two movements in twenty-four hours, or to check evacuations when there were more than four in that time. He did not attempt to reduce temperature unless it rose above 104 degrees F. In such instances the cold pack to the thorax and abdomen was employed. The cold pack applied to the head usually would relieve restlessness, irritability and sleeplessness. This method of treatment had the advantage of a milder course, shorter duration, more prompt convalescence, and usually absence of complications.—*The Canada Lancet.*

The *Dietetic and Hygienic Gazette* says: "For thirst in surgical operations it will be well to remember Semmola's glycerine drink, which is often exceedingly grateful. It is one ounce glycerine and thirty grains citric acid to a pint of water."

INFANT FEEDING:—*The Canada Lancet* gives the following on "Modified Cow's Milk as a Substitute Food in Infant Feeding":—

"The subject of modified milk as a substitute food for infant feeding has been studied from many points of view, but two facts are being recognized, more and more, as of prime importance, first, that cow's milk is the most practicable substitute food for infants, and second, that it is just as important that the physical characteristics of cow's milk be modified, as to the proportions of its food elements.

It is along these lines that First Lieut. W. E. Fitch, of the Medical Reserve Corps, United States Army, has written a most practical paper upon the subject of "Modified Cow's Milk as a Substitute Food in Infant Feeding," published in *Pediatrics* (October, 1912). He studies the comparative chemical composition of healthy woman's milk and

cow's milk, the general availability of cow's milk as a substitute food, the physicial and chemical differences between cow's milk and woman's milk, and the modification of cow's milk with cereal decoctions.

He emphasizes the necessity of using pure cow's milk, not milk that has been pasteurized or sterilized, but fresh, wholesome milk from a healthy herd. We all recognize the fact that the milk offered for sale in the large cities is not as pure as it should be, but under the active work of the Boards of Health and the medical profession, it is rapidly improving in quality. When procurable, certified milk should always be used.

Dr. Fitch points out the fact that the modification of cow's milk with a cereal is a mechanical one, due to the gelatinized starch, which changes the hard curdling cow's milk into a soft curdling milk like human milk. The casein of cow's milk clots in hard, lumpy masses in the infant stomach, the digestive enzymes cannot get at it, and any means whereby we can break up the clot and make it more flocculent will increase the digestibility of the milk; and this can be done by the use of a properly prepared cereal decoction.

Not only do cereals modify the casein of cow's milk, but they, also, through their gelatinized starch, facilitate the digestion of fats, by emulsifying the fats after proteid digestion in the stomach. This is important because, as Holt shows, the tendency to-day is to give a large percentage of fat, and the fats of cow's milk are more difficult to digest than the fats of human milk. With many infants it is often necessary to begin with an amount less than two per cent. of fat, and rarely is it necessary to exceed four per cent. There are numerous healthy infants who cannot even digest four per cent. of fat at any time, and many during the hot weather do better on a reduction to 3 or 3.5 per cent.

Theoretically, the child under six months, because of the deficiency of salivary and pancreatic secretions, is said to be incapable of digesting starches. Practically, this is not true. Nearly every fluid in the human economy has a diastatic ferment and as a matter of fact the very young infant does digest starch. We have seen, too, many babies successfully fed on arrow root to deny this fact. The author quotes Finkelstein, in Berlin, whose experience and general sound judgment are respected by the leading pediatricians of the world, who is emphatic that very young children are capable of digesting starches, and quotes favourable published opinions of Jacobi, Epstein, Schmid, Minard, Keller, Newman, Heubner and others, while our own Kerley has conclusively shown by his experiments at the New York Infant Asylum, that 'There is no age limit for cooked starch feeding.'

The addition of cereals to cow's milk is not only allowable, but is to be most warmly recommended, not only in older, but also in very young infants. The advantages of cereal modification, in addition to

the readier digestion and gain in weight, are to be found in the finer subdivision of the casein in the stomach, in the emulsification of the fat, in the disappearance of soapy and dyspeptic stools, in the proteid-sparing power afforded by the cereals, and, finally, in the general increment of growth.

This is the experience of the leading pediatrists of the world. Not every infant, by any means, can take cow's milk, or ass's milk, or goat's milk; but starch foods may be added with benefit to cow's milk in the majority of cases, is established beyond all question, experimentally, chemically and clinically.

Dr. Fitch then considers the practical details of cereal modification, and gives formulas for milk mixtures, based on years of successful use. He gives, also, clinical reports upon a number of cases had with these formulas.

The article is an exceedingly clear and practical consideration of the much-befuddled question of the modification of cow's milk for infant use; and best of all, it contains usable information."

How to Give a Fomentation:—Doubtless every physician knows how to apply a fomentation, yet the following suggestions may be of interest to someone (*Jour. Bact.*): A flannel cloth may be folded, wrung out of hot water and applied directly to the skin; nevertheless, it is much better, after wringing out the flannel as dry as desired, to fold it in a dry flannel cloth of one or two thicknesses before applying it to the patient. A little time is required for the heat of the fomentation to penetrate the dry flannel, and thus the skin is allowed an opportunity to acquire tolerance for the heat, and a greater degree of temperature can be borne than if the moist cloth is brought directly in contact with the surface. The outer fold of dry flannel will also serve to keep the cloth warm by preventing evaporation. A fomentation is sometimes needed when no hot water is at hand. It is not necessary to wait for water to be heated in the usual way. Soak the flannel in cold water, wring as dry as desired, fold in a newspaper, and lay upon the stove or wrap it about the stovepipe. In a few minutes it will be as warm as the patient can bear. The paper keeps the pipe from becoming moistened by the wet flannel, and at the same time prevents the flannel from being soiled by contact with the pipe. Fomentations, thoroughly applied, will relieve most of the local pains for which liniments, lotions and poultices are generally applied, and are greatly to be preferred to these remedies, since they are cleaner and aid nature more effectually in restoring the injured parts to a sound condition.—*Dietetic and Hygienic Gazette.*

For patients who are not allowed meat broths and who may have a distaste for milk, I find the following soup very good: Cut up a potato in small pieces, and with a little bit of onion, pepper and salt, boil in a

small quantity of water until the potato is quite soft. Add one cup of milk and a small bit of butter; bring to the boil, and put through a sieve. Serve with toast.

No substance is equal in power to glycerine in disguising nauseous medicines. Castor oil, turpentine, solutions of iron and various other medicines can be diluted and at the same time almost completely disguised by glycerine. The secret of taking unpleasant medicines without tasting them lies almost entirely in removing all traces of the drug from the mouth before drawing a breath after swallowing it. For cleansing the mouth after castor oil or other oils, probably nothing is better than chewing up and spitting out a liberal quantity of bread. Do not, however, as one nurse did, bring the bread to the patient spread with butter.

A UNIQUE ENTERPRISE.

The Pacific Coast Journal of Nursing gives an interesting account of what was certainly a unique enterprise, but one that was without doubt successful, and evidently filled a need before unrealized. The enterprize—the Home Bureau Medical House—was founded and managed by Mrs. W. H. Willard, its President, with what success the following story will tell:—

"In one back room twenty years ago in the City of New York was 'born an idea,' a diet kitchen for the manufacturing of scientifically prepared foods for the sick. A maid, the only employee, who was generally cook and bottle washer, prepared six quarts of broth for the customers who were expected on the opening day. But, alas! no one came, and the following day was spent in waiting for the arrival of the long-wished-for buyer. On the third day one customer came and it was an exciting moment when he bought and paid for a quart of chicken broth; and thus the enterprise was launched.

In those early days it could not be foreseen that from this small beginning so large an enterprise would develop as that of the Home Bureau-Medical House. The success of this novel undertaking has been due to its unique business methods and its policy of giving the public what it wanted and when it wanted it. For twenty years the doors of this establishment have always been open and many lives have been saved because proper nourishment and supplies could be obtained night or day, Sundays and holidays. When other establishments in the early hours of the morning closed their doors, so that even ice and milk could not be obtained in the great City of New York, the Home Bureau supplied these products, and its grateful patrons have published, far and near, the wonderful efficacy of a system which was always ready to meet the needs of the sick. Soon after "the start," trained nurses who came to purchase

foods for their patients often inquired if the Home Bureau knew of any sick persons who might need their service, and customers asked about nurses, so the Registry Department was started with one nurse, but it was not long before two houses in the neighbourhood of the office were rented to accommodate the members. The work grew rapidly, and the Home Bureau-Medical House has now the largest registry in the world, and is recognized as the national headquarters for nurses desiring hospital and private work. The methods employed to develop this department were the same as those used for the diet-kitchen department, every effort being made for doctors and patrons to secure the services of a nurse when she was needed. Telephones in those early days were unknown, and messengers at all hours of the night went hurrying about from one house to another, until a nurse was found who could respond to the call. Following fast upon the development of the Registry Department, the Invalid Supply and Surgical Departments were added, and an extra floor was rented to provide space for this new work.

One day a doctor entered the office and asked if he could rent a stretcher. He stated that he must have one at once to move a patient. The hospitals could not accommodate him, and he hoped the Home Bureau would help him out. A stretcher was bought and rented, and that was the beginning of the department for invalid furniture.

Finally the business outgrew its original quarters and moved to its present address, 52 West 39th Street, but this building is also becoming congested and crowded, as, with the rapid growth of the enterprise, it has been necessary to add several other departments. There are apartments for canvalescent patients, infants' and children's departments, a hygiene and disinfecting department, and a department devoted to the moving of patients from hospitals to home or from the city to the country. "Not what we have, but what you want," is the motto of the Home Bureau-Medical House, and as it is called upon to take up new work, still other departments will be added.

Visitors are always welcome, and they are shown through every department of this interesting enterprise, from the dainty kitchen spotlessly clean to the surgical room, perfectly equipped with sterilizers and with the machinery for manufacturing maternity outfits and dressings.

The nurses' reading-room and the system for registering the hundreds of nurses who apply for membership, and the methods of sending them to cases and hospital positions throughout the country, come in for a large share of attention. The rest-cure apartments, furnished in old mahogany and with the accessories which make rooms home-like and cosy, can also be visited. The time spent in seeing the Home Bureau and its several departments is considered worth while by the hundreds of visitors who come from every part of the country to inspect its facilities for supplying all necessities for the sick-room and hospital."

Editorial

THE DUTY OF AFFILIATION

Appended to the report of the Publications' Committee of the Canadian National Association of Trained Nurses, published in this issue, is a list of the affiliated associations at the time of the annual meeting of 1913. There were then added the Nova Scotia Graduate Nurses' Association and the Saskatchewan Graduate Nurses' Association, thus making twenty-eight associations in the membership list of the national organization.

It will be admitted at once that this is not as it should be. Every Association in Canada should see that its name is entered on the roll of the National Association.

The objects of the National Association are:

1. To encourage mutual understanding and unity among associations of trained nurses in the Dominion of Canada;

2. To acquire a knowledge of the methods of nursing in every country, to elevate the standard of professional education and promote a high standard of professional honor among nurses in all their relations, to encourage a spirit of sympathy with the nurses of other countries, and to afford facilities for international hospitality.

Every Association will, without doubt, put the stamp of its approval on these objects. Then why not go a step further and help in attaining them.

This has not been done by some, perhaps through lack of thought or because the matter has not been brought to their attention. Do not longer delay seeking the affiliation of your Association with the National. Mutual help, greater strength and efficiency and a broader outlook for both will result.

A RAY OF LIGHT

The eight hour day for pupil nurses has been advocated by many supintendents of nurses, approved by more, and instituted by a few. So often hospital authorities have blocked the reform by that ever ready excuse—lack of funds and the necessary accommodation.

That the overstrain resulting from the long hours of toil has spelled broken health for some and deterred others from entering a training school never seemed to be considered.

But a light is dawning for the pupil nurse. Not much longer

will hospitals exploit her health and energy that their work may be done at a minimum of cost. In California the law has stepped in and laid its regulating hand on her hour of duty, and nurses everywhere will watch with peculiar interest the working out of this law.

The Pacific Coast Journal of Nursing says: "This radical change in the working schedule for pupil nurses will, without doubt, test the generalship of the superintendents in every hospital in the state. A number of these superintendents, however, possess generalship. It rests with the superintendents to shine in generalship and demonstrate that this full one day rest in seven on an eight hour day can be worked out to the advantage and satisfaction of patient, hospital board and pupil."

Would it not have been evidence of even greater generalship if these superintendents had brought about this reform without the "must" of the law.

A CAMPAIGN AGAINST VENEREAL DISEASE IN CANADA.

The Canadian Journal of Medicine and Surgery, speaking editorially on this subject is of the opinion that a campaign against venereal disease, if carried on with the same vigor and intelligence that characterizes the campaign against tuberculosis, would speedily result in a wonderful improvement in the public health, "for these two general infections dominate the field of pathology."

We glean these facts about what Australia is doing along these lines:

In 1908 the Australian Medical Congress passed this resolution: "That syphilis is responsible for an enormous amount of danger to mankind, and that preventive and remedial measures directed against it are worthy of the utmost consideration."

This aroused public interest and a deputation of clergy waited upon the Premier of Victoria and asked that some action be taken. The Government consulted its Medical Officer, Dr. Barnett Ham, who advised a comprehensive inquiry into the extent of the prevelance of syphilis. The result of this enquiry, which was systematic and thorough, was the formation of a "permanent advisory committee of medical men and women, by the Victorian Government, under the presidency of Dr. Ham, which at once made it known that, whilst the members would informally support any moral campaign, its business in a corporate capacity was to teach the people how to prevent infection and to render those infected no longer dangerous to others. This was to be done by open educational means. Newspapers were to publish official and unexpurgated accounts of the steps taken, to

call these diseases by their proper names, and to abandon the ostrich-like attitude generally adopted in regard to them. This request was agreed to, and such reports have since been regularly published."

"The Victorian Government then decided to equip and maintain at its own expense, a ward at the Alfred Hospital and one at the Women's Hospital, at Melbourne, for the treatment of persons of any class, except prostitutes, for whom other arrangements exist, and the profession was asked to send such cases for indoor treatment. The Government has further arranged with the University of Melbourne for the free application of the Wassermann test to 2,000 hospital cases a year and to all other cases, at a low rate of payment. Lastly, it is proposed to introduce legislation, providing that a person sentenced to a term of imprisonment, for any cause, can, if found suffering from a contagious veneral disease, be detained until he can be released without risk. Founded on an investigation as to the extent of the distribution of venereal diseases in Melbourne, followed up, when this had been ascertained, by a combined attack on medical lines, the campaign against venereal diseases in Melbourne promises well. In the work of education and repression the clergy have been of great service."

Vigorous, sustained effort of this sort will do much towards eliminating this scourge, especially when the education of our boys and girls in sex hygiene assists by doing away with the ignorance which has so often been the cause of their undoing.

The Guild of Saint Barnabas

CANADIAN DISTRICT

MONTREAL—St. John Evangelist, first Tuesday Holy Communion at M. G. H., 615 a.m. Second Tuesday, Guild Service or Social Meeting, 4 p.m. Third Tuesday, Guild Service at St. John's, 8.15 p.m. Last Tuesday Holy Communion at R. V. H., 6.15 a.m.
District Chaplain—Rev. Arthur French, 158 Mance Street.
District Superior—Miss Stikeman, 216 Drummond Street.
District Secretary—Miss M. Young, 36 Sherbrooke Street.
District Treasurer—Miss F. M. Shaw, 21 Sherbrooke Street.

TORONTO—Nurses' Residence, H.S.C. last Monday 8 p.m.
Chaplain—Rev. F. G. Plummer, 6 Spruce Street.
Superior—Miss Brent, Hospital for Sick Children.

QUEBEC—All Saints Chapel, The Close. Guild service, fourth Tuesday, 8.15 p.m.
Chaplain—The very Rev. the Dean of Quebec.
Superior—Mrs. Williams, The Close.

The following extract from an address to the Guilds of St. Alban's, Holborn, by the Ven. Archdeacon Holmes, on St. Alban's Day, copied from "Misericordia," may be of interest, and is certainly applicable to others besides members of the above mentioned guilds:

"I think sometimes that the sin of grumbling because we cannot see what we are doing for others is rather under-rated. If it is true that upon the well-doing of each depends the well-being of all, every one of us has got a vocation; every one of us is doing something for somebody else. That, I suppose, is why you belong to a guild. It is not only that you may get something from, but that you may contribute something to, the corporate life of this or that guild, of which you are members. To deliberately, and unnecessarily, miss going to a guild meeting, or saying the guild prayer; to miss giving a helping hand to another member of the guild who is in need—all means you are spoiling the perfect life and work of your guild, and endangering its perfection..... There then is the sentence we are going to take away as our motto for another year:—

"Upon the well-doing of each depends the well-being of all."

THE GRADUATE NURSES' ASSOCIATION OF ONTARIO

(Incorporated 1908)

President, Miss Bella Crosby, 41 Rose Ave., Toronto; First Vice-President, Mrs. W. S. Tilley, 56 George St., Brantford ; Second Vice-President, Miss G. A. Read, 156 John St., London; Recording Secretary, Miss Ina F. Pringle, 188 Avenue Road, Toronto; Corresponding Secretary, Miss Jessie Cooper, 30 Brunswick Ave., Toronto; Treasurer, Miss Julia F. Stewart, 12 Selby St., Toronto. Directors: Mrs. W. G. Struthers, 558 Bathurst St., Toronto; Mrs. A. H. Pafford, 194 Blythewood Road, North Toronto; Miss Mathieson, Riverdale Hospital, Toronto; Mrs. Mill Pellatt, 36 Jackes Ave., Toronto; Miss M. Ewing, 295 Sherbourne St., Toronto; Miss Eastwood, 206 Spadina Ave., Toronto; Mrs. Clutterbuck, 148 Grace St., Toronto; Miss Jean C. Wardell, R.N., 84 Delaware Ave., Toronto; Miss Eunice H. Dyke, City Hall, Toronto; Mrs. Yorke, 400 Manning Ave., Toronto; Miss G. L. Rowan, Grace Hospital, Toronto; Mrs. MacConnell, 127 Major St., Toronto; Miss Mary Gray, 505 Sherbourne St., Toronto; Miss J. G. McNeill, 52 Alexander St., Toronto; Miss C. E. De Vellin, The Alexandra Apts., University Ave., Toronto; Miss E. M. Norris, 82 Isabella St., Toronto.

Conveners of Standing Committees: Legislation, Mrs. Paffard; Revision of Constitution and By-Laws, Miss Dyke; Press and Publication, Mrs. Struthers. Representative to The Canadian Nurse Editorial Board, Miss E. J. Jamieson.

The announcement, by Sir James Whitney in his speech at the opening of the new Toronto General Hospital, that a Royal Commission would be appointed by the Provincial Government to enquire into the whole system of medical education in Ontario, was an important one in that nursing and the schools for training nurses are included.

This investigation should bring forward much information and be a means of education to many.

Will it really help us in securing legislation that will give us uniform standards and really define "trained nurse?" The nurses of Ontario may do much to bring about this desirable result.

THE ALUMNAE ASSOCIATION OF THE HAMILTON CITY HOSPITAL TRAINING SCHOOL FOR NURSES.

President—Miss Coleman, 171 James St. South.
Vice-President—Miss Dressel, 58 Charlton Ave. East.
Recording Secretary—Miss M. E. Dunlop, 175 Charlton Ave. East.
Corresponding Secretary—Miss E. F. Bell, 274 Charlton Ave. West.
Treasurer—Mrs. Reynolds, 143 James St. South.
"The Canadian Nurse" Representative—Misss Bessie Sadler, 100 Grant Avenue.

Miss Elizabeth Giffin, Class '03, has been appointed night Supervisor of Grant Memorial Hospital, Columbus, Ohio.

Miss Dunlop, Class '06, has returned to the city after accompanying her patient on a three months' tour in Europe.

Miss Wright, Class '08, had to give up her professional work in the city and remain at her home in Conestogo, Ont., owing to her father's illness.

Most of the nurses who have been enjoying their well-earned holiday have returned and are very busy again.

Uttermach-Roberts—In New York, on July 19th, Captain Fritz Emmerich Uttermach, to Miss Francis Ada Roberts, Class 1898. Miss Roberts, who is a sister of Dr. Roberts, Medical Health Officer of Hamilton, has for the past five or six years held a position with the Department of Health in New York City.

THE CANADIAN NURSES' ASSOCIATION AND REGISTER FOR GRADUATE NURSES, MONTREAL.

President—Miss Phillips, 43 Argyle Ave.

Vice-Presidents—Mrs. Petrie and Miss Dunlop.

Secretary-Treasurer—Miss Des Brisay, 16 The Poinciana, 56 Sherbrooke Street West.

Registrar—Mrs. Burch, 175 Mansfield St.

Reading room—The Lindsay Bldg., Room 319, 517 St. Catherine St. West.

Mrs. Burch, our Registrar, visited Toronto during the Exhibition.

The Nurses' Directory has been published and will prove a help to many, especially those living outside the city.

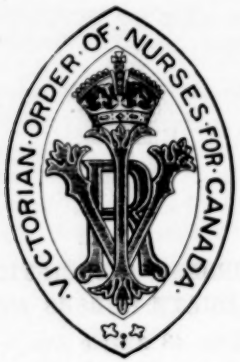
Miss Colley has returned, after an absence in England, of fifteen months.

Miss Hill has returned to town.

The annual meeting will be held on Tuesday, October 7th, for the hearing of reports and election of officers for ensuing year.

A fine thought or beautiful image, once stored in the mind, even if at first it is received indifferently and with little understanding, is bound to recur again and again, and its companionship will leave a sure if unconscious influence.—*Una.*

Do not look on your work as a dull duty. If you choose you can make it interesting. Throw your heart into it . . . even if at first you find this impossible, if for a time it seems mere drudgery, this may be just what you require; it may be good, like mountain air, to brace up your character.—*Lord Avebury.*



Miss Stoer is in charge of the country district at Gaspe, Quebec.

A milk station was opened at Halifax, July first, with Miss Murison in charge.

The Ottawa district has been very busy during the summer.

A resident nurse, Miss Bottlelet, has been placed in the Eastview district.

Miss Griffiths is the V.O nurse in Cobalt.

A very well-attended meeting was held in Uno Park, when a committee was appointed to organize a country district nurse association for Uno Park and the surrounding villages.

The very handsome hospital which is being built in Coppercliff to replace the one which was destroyed by fire over a year ago, is nearing completion.

Chapleau, Ontario, and Tofield, Alberta, are to build hospitals in connection with the Victorian Order.

The Innisfail, Alberta, committee are planning to build a nursing home in connection with their country district.

Miss Kervin has been appointed Matron of the Lady Minto Hospital, at Islay, Alberta, and Miss Higgins Matron of the Victorian Hospital, Swan River, Manitoba.

Miss Hewetson has received the appointment of Matron of the Victorian Hospital, at Kaslo, B.C. Miss Hewetson succeeds Miss Alexander, who has filled the position very creditably for some seven years.

The new Lady Minto Hospital at Ashcroft, B.C., was formally opened, August 8th. Miss Crompton is in charge, assisted by Miss M. H. Pepper.

Miss Moreau has been appointed Head Nurse of the Victoria district.

Miss MacMann is in charge of the newly opened district at Steveston, B.C.

Miss Winter is the nurse on the Saskatoon district, and Miss Le Moine, on the North Bay district.

Miss Covey is on the Edmonton district.

The Victorian Order of Nurses for Canada offers a post-graduate course in district nursing and social service work. The course takes four months and may be taken at one of the Training Homes of the Order: Toronto, Ottawa, Montreal, Vancouver. For full information apply to the Chief Superintendent, 578 Somerset street, Ottawa, or to one of the District Superintendents at 206 Spadina avenue, Toronto, Ont.; 46 Bishop street, Montreal, Que.; or 1300 Venables street, Vancouver, B.C.

HOSPITALS AND NURSES.

We regret the error in the June issue regarding the appointment of Mrs. Mathieson. She is in charge of the Diamond Jubilee Hospital, at Fort Steele, B.C.; not the Fernie Hospital.

Miss Grace Hastie, who preceded Mrs. Mathieson in Fort Steele, is now doing private nursing.

We are grateful to our correspondent for correcting us.

Mrs. Feeny, of the School Staff, Toronto, had a delightful holiday across the Atlantic.

Miss Edith Weller, R.N., of Tacoma, Wash., has just returned from a very pleasant vacation trip to Alaska.

Miss Morton and Miss Carr, of Collingwood, have returned from their trip to Boston, where they attended the meeting of the American Hospital Association. On their way home they visited New York and Providence.

Miss Browne, Class 1911, has moved to Stayner, where she will take up private nursing.

The twenty-third graduating exercises of the Grace Hospital Training School for Nurses were held the evening of May 29th, in the Metropolitan Assembly Rooms, 249 College street, Colonel Arthur Peuchen, a member of the board of convenors, occupying the chair. The proceedings were opened by the Rev. T. Crawford Brown who offered the invocation.

The address to the Graduating Class was given by Dr. N. A. Powell, whose words of counsel and advice will long be remembered by all nurses present, both graduates and pupils.

The Florence Nightingale oath was administered to the Graduating Nurses by Miss Rowan, after which Mrs. Peuchen presented the

diplomas. Mrs. Currie, a former superintendent, presented the school pins, and spoke a few appropriate words to the Graduates.

The Vander Smissen medal, given by Prof. and Mrs. Vander Smissen, and open to members of the Graduating Class, was presented to Miss Edith O. Holland by Dr. J. L. Forester. Mrs. R. B. Hamilton presented her prize for neatness to Miss Jessie Murray. The Medical Superintendent's prize for proficiency in bandaging in the second year was awarded to Miss Ellen Davidge. The Dietitian's prize for proficiency in the diet kitchen during the past year was presented to Miss Florence Sinclair. The Principal's prize for general proficiency, open to pupils in the first year, was awarded to Miss Evelyn McKay.

The young women who received their diplomas were:—Winnifred Jessie Stagg, Jessie Broadfoot Murray, Elsie Patton, Jean Muir Tod, Sadie Emma Might, Bessie Leoline Fisher, Mildred Dewey Manhard, Una Alexandria McRoberts, Ethel May Sharp, Harriet Annie Hay, Margaret Wilson, Edith Octavia Holland, Helen Lauder Fowlds, Ella Gardiner Upper.

The Graduating Class assisted by Dr. Beatty and Miss Rowan, held a reception and received the congratulations of their many friends, after which an informal dance was held.

The crimson roses carried by the Nurses were presented by the members of the medical and surgical staff.

Two members of the Registered Nurses' Society of London, England, recently returned home after four and a half months' work under the British Red Crescent Society for the Turkish wounded. These nurses also worked in Bulgaria and received from the Bulgarian Government a decoration and illuminated diploma in grateful recognition of their services during the war, 1912-1913.

The British Journal of Nursing shows a beautiful cut of this decoration, and thus describes it and the diploma:

"We are able to reproduce the decoration given to the Sisters, the design of which is a red cross on white enamel, on a gilt background, surmounted by a crown, carried out in gilt, red and white. The diploma is on a buff ground, illuminated in red, blue and green, most artistically blended, with insets showing a Red Cross worker giving a drink to a wounded soldier, and a hospital with mountains in the background. It also bears the Red Cross seal.

The Henry Phipps Institute, Philadelphia, has instituted a post-graduate course of eight months, in public health work, for nurses who wish to equip themselves for this branch of work .

The course is divided into terms of four months each in the hospital and in the Social Service Department.

In the hospital there will be instruction in the practical details

of management of hospital and dispensary, in invalid occupations such as basketry, etc. In the social service department there will be lectures, class and field work in the following subjects: Hospital social service, nursing of the tuberculous in the home, medical inspection of public schools and factories, housing problems, bacteriology, practical dietetics, industrial hygiene and public health problems. In both departments, the mornings will be occupied in practical work, leaving the afternoons free for lectures, etc.

Miss A. K. Sutton, Superintendent, will gladly furnish entrance blanks and an outline of the curriculum, on request.

Miss Gillis, Graduate of Boston City Hospital, who has acted as nurse for the Anti-Tuberculosis Auxiliary, of Vancouver, B.C., for some time, is leaving to be married. The members of the Auxiliary regret exceedingly to have to accept the resignation of their nurse who has done such efficient work during her term of office, and feel that they owe a debt of gratitude to Miss Gillis for the interest she has displayed in her work and for the able way she overcame the many difficulties incident to her duties.

Miss Margaret Robertson, Superintendent of the Nanaimo General Hospital, has left for the east.

Miss S. Arthur (P.E.I.), who has been doing private nursing in Vancouver, has taken charge of the hospital at Powell River, B.C.

The annual meeting of the Alumnae Association of the Mack Training School for Nurses, St. Catharines, was held at the Nurses' Home, Queenston street, August, 27th, at 2.30 p.m.

Among those present were: Mrs. Dr. Mitchell, of Macoun, Sask.; Miss Elliott, Memorial Hospital, Niagara Falls, N.Y.; Miss McIntosh, of Buffalo; Miss Lymburner, of Niagara Falls, Ont.; and others.

Misses Golden, Bowman, Lovell, Grenville and Thomson were accepted as members of the Association.

Miss Shantz was elected Prisident; Mrs. Parnell, First Vice-President; Mrs. Dunn, Second Vice-President.

Miss Albright was reappointed Secretary, Miss A. E. Moyer, Treasurer.

A motion was passed allowing outside Graduates to attend monthly meetings, but they may not vote

Misses McPhee and Boutcher were appointed a committee with the President to draft programme for meetings during coming year.

The Secretary was authorized to send in resolution to Secretary of Hospital Board in reference to Registration.

It was decided, after some discussion, to allow all Graduate Nurses to register, on payment of a fee of $5.00, and $1.00 per year, payable

in advance. Fees are to be passed over to the Secretary of the Alumnae Association to dispose of as Alumnae sees fit, for the benefit of the Nurses' Home.

Misses Albright and Moyer were appointed a committee to see to placing of advertisement prepared by The Graduate Nurses' Association of Ontario.

Mrs. (Dr.) Mitchell (nee Miss Smith), of Macoun, Sask., is visiting her mother, Mrs. Smith, of Duke street, city.

A very pleasant evening was spent at the Nurses' Home, Sept. 10th, in honor or Mrs. Dr. Mitchell, of Macoun.

The Alumnae wished to express to the retiring President, Mrs. Parnell, its sincerest appreciation of her unselfish endeavors to promote the interest of the Association.

On behalf of the Society a letter of appreciation was read by Miss Elliott, of Niagara Falls, and presented to Mrs. Parnell, together with a handsome silk umbrella.

Mrs. Parnell has for years been a most efficient President, and her retirement on account of ill health in the family is much regretted.

The annual visit of Miss McKenzie, Superintendent of the Victorian Order of Nurses of Canada, to Cobalt recently, was the occasion of a very enjoyable social afternoon at the Mines' Hospital. Mrs. Saunders, Superintendent of the Hospital, invited all the available Graduate Nurses, whether engaged in active nursing or residents of the district, to hear an address by Miss McKenzie, on "Registration," given in the Assembly Room of the Y.M.C.A. A dainty tea was afterwards served in the hospital garden. The following were present: Mrs. Lorne Campbell, Haileybury; Miss McKay, Toronto; Misses Panton, Toronto; Miss Jean Bell, Florida; Miss Fitzgerald, Superintendent Lady Minto Hospital, New Liskeard; Miss Nye, Lady Minto Hospital, New Liskeard; Miss Griffiths, V. O. Nurse, Cobalt; Mrs. Jno. Leigh, Cobalt; Mrs. A. N. Morgan, New Liskeard; Mrs. R. Watson, New Liskeard; Mrs. D. Jennett, Cobalt; Mrs. A. N. Davis, Cobalt; Mrs. H. Dixon, Cobalt; Misses Oliver, Fitzpatrick, Mills and Haggart, Cobalt; Mrs. Dr. Hair, Cobalt; Miss Telfer and Miss Hicks, of the Cobalt Mines' Hospital Staff: Dr. C. H. Hair, Cobalt; the Rev. John Leigh, Cobalt. As a result of this meeting it is hoped to hold a meeting in New Liskeard, Sept. 13th, 1913, to form a branch of the Graduate Nurses' Association of Ontario.

On the afternoon of August 30th, Miss R. L. Stewart and the officers of the Training School of the Toronto General Hospital were At-Home to the members of the Alumnae Association and all Graduates of the school. A large number responded to Miss Stewart's invitation and enjoyed the opportunity of seeing the beautiful new Nurses'

Residence. The officers of the school were most kind in showing the guests about the Residence. Miss Robinson, who is in charge of the Residence, presided at the tea table.

The members of the Alumnae Association presented Miss Stewart with an address and a handsome bracelet watch in token of their appreciation of her splendid work in the training school, her unfailing kindness to the Association, and the love and loyalty she had inspired in the members.

Miss Clara Evans, graduate of Toronto General Hospital, class '01, and late of Toronto Hospital for Incurables, has gone to White Horse, Yukon, to take charge of the hospital there.

LUMBAR PUNCTURE.

By Hazel Southard.

A lumbar puncture is done for two principal reasons: as a diagnostic measure, and as a therapeutic measure to relieve pressure in the spinal canal caused by an excess of fluid such as is present in all forms of meningitis, hydrocephalus, hemorrhage into the spinal canal, etc. Where there is an excess of fluid, great relief is often afforded the patient.

As a diagnostic measure it is very valuable, as, for instance, in the epidemic form of cerebro-spinal meningitis and specific organisms may be found. The method, if properly done, is a safe one. The patient is placed on his side close to the edge of the bed, the shoulders are bent towards the knees and the knee drawn up towards the chest as far as possible. In this way the laminæ of the vertebræ are separated and allow a larger space for the entrance of the needle. Pillows placed under the shoulders, and thereby raising them, sometimes help. It is advisable to cocainise the parts before the insertion of the needle, and, if the patient is at all hard to manage, a general anæsthetic may be given.

Thoroughly scrub over the lumbar vertebræ and for quite a space around with green soap and sterile water, using sterile gauze. This is followed with ether, alcohol and bichloride solution. Sterile towels are placed around, making a sterile field, and the operator, after scrubbing his hands, wears sterile gloves. The space between the fourth and fifth lumbar vertebræ is the place generally chosen, as pus-cells, bacilli, etc., tend to gravitate toward the lowest portion of the dural sac where they might escape observation if the puncture is performed too high. With one finger on the spinous process of the fourth lumber vertebræ the needle is inserted just opposite about 2 cm. to one side of the median line and at an angle, so that upon entrance of the canal it will be about in the middle. A small glass test-tube is held under the needle to catch the fluid. The needle must have a sharp point, because a dull point may

push the membranes ahead, instead of going through them, and all efforts be fruitless. The pressure is determined by the rapidity with which the fluid appears; if drop by drop, then a low pressure. Too much fluid should not be withdrawn because of the dangers when there is too low a pressure. Clear fluid may not always be normal. A collodion dressing or sterile gauze with straps of adhesive may be applied after the withdrawal of the needle.—*American Journal of Nursing.*

SCHOOL FOR HEALTH OFFICERS, CONDUCTED BY HARVARD UNIVERSITY AND THE MASSACHUSETTS INSTITUTE OF TECHNOLOGY.

Beginning this fall Harvard University and the Massachusetts Institute of Technology are to maintain in co-operation a School for Public Health Officers. The facilities of both institutions are to be available to students in the School and the Certificate of Public Health (C.P.H.) is to be signed by both President Lowell and President Maclaurin.

The object of this School is to prepare young men for public health work, especially, to fit them to occupy administrative and executive positions such as health officers or members of boards of health, as well as secretaries, agents, and inspectors of health organizations.

It is recognized that the requirements for public health service are broad and complicated, and that the country needs leaders in every community, fitted to guide and instruct the people on all questions relating to the public health. To this end, the instruction of the new School will be on the broadest lines. It will be given by lectures, laboratory work, and other forms of instruction offered by both institutions, and also by special instructors from national, state, and local health agencies.

The requirements for admission are such that graduates of colleges, or technical and scientific schools, who have received adequate instruction in Physics, Chemistry, Biology, and French or German, may be admitted to the School. The medical degree is not in any way a prerequisite for admission, although the Administrative Board strongly urges men who intend to specialize in public health work to take the degree of M.D. before they become members of the School for Health Officers.

The Administrative Board which will conduct the new School is composed of Professor William T. Sedgwick, of the Massuchesetts Institute of Technology; Professor Milton J. Rosenau, of Harvard; and Professor George C. Whipple, of Harvard. Professor Rosenau, of Harvard, has the title of Director, and the work of the School will be under his immediate supervision.

MARRIAGES.

Brochel-Dale—On Monday, May 5th, 1913, at Toronto, Sadie A. Dale, Graduate of Grace Hospital, Toronto, Class 1911, to Philip Freeman Brochel, Montreal.

Henry-Dafoe—On July 30th, 1913, at Madoc, Ont., Miss Lois Essa Dafoe to Mr. Stanley Hunter Henry, M.A.

McPherson-Sparkhall—On August, 22nd, at St. Barnabas Church, Toronto, by Rev. F. E. Powell, Miss Mabel E. Sparkhall, Graduate of the Hospital for Sick Children, Toronto, to Dr. W. A. McPherson, Peterborough, Ont.

Morris-Mott—On Thursday, August 14th, 1913, by Rev. H. B. Kenny, Miss Carrie Mott, Graduate of the Hospital for Sick Children, Toronto, to Mr. Francis F. Morris, of Bowmanville, Ont.

Wood-Stephens—On June 19, 1913, at Great Falls, Montana, U.S.A., Mary Elizabeth Stephens, Graduate Grace Hospital, Toronto, Class 1911, to Richard Wellington Wood, Alameda, Sask.

THE NURSES' LIBRARY

"The History of Nursing," Volumes III. and IV. By Miss Lavina L. Dock, R.N. Secretary of the International Council of Nurses; Graduate of Bellevue Training School, New York City. G. P. Putnam's Sons, New York and London.

These volumes, which give the history to the present, are intensely interesting. Here, for our enlightenment, is the story of the beginnings in the different countries.

Great Britain and Ireland: These chapters tell of steady progress all along the line, but not the least interesting is the story of the struggle for State Registration. Many and great have been the obstacles, but the intrepid leaders have always been alert and ready. The end, however, is not yet.

United States: Training schools here from the first benefited by the teachings of Florence Nightingale, and the march in progress has been steady. State Registration is in force in many states. It is interesting to note the advance of standards—of work and education, and progress of organization.

The chapters on Northern Europe include Sweden, Denmark, Finland and Norway.

The third volume closes with "The Revolution in French Hospitals."

The fourth volume deals with Germany, Switzerland, Holland, Belgium, Italy, Spain, Canada, Newfoundland, Australia, Africa, India, China, Japan, Cuba and the Phillipines.

A wealth of information is at the command of every nurse, for none should rest content till she has read the whole four volumes of the "History of Nursing." Nursing organizations should see to it that their members have access to them in some way. The profession will always be indebted to Miss Nutting and Miss Dock for this great and wonderful work, so unselfishly undertaken and so nobly and creditably completed.

WOMAN'S CENTURY

This new paper is, as its name implies, owned, managed and edited by women. The editor is Mrs. Campbell-MacIver, and co-operating with her are: The King's Daughters of Canada, The Women's Canadian Club, The I.O.D.E., The W.C.T.W., The United Suffrage Societies, The Business Women's Club, and other allied bodies representing all progressive Canadian women.

The fourth number appeared in August. In "Comment and Review" you learn much of women's humanitarian work in different parts of the world. "What our Women are Doing" tells very clearly

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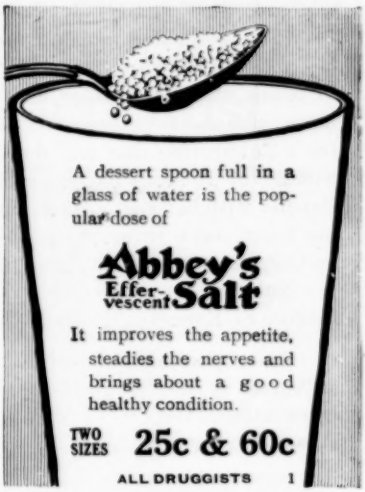

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what has been accomplished by the plucky work of some women in Calgary, and other places. Then there are several pages devoted to "Special Articles," and a department "Woman Suffrage," with its watchword—Equality, Justice—and "Home Hygiene."

"This is the first woman's paper in Canada which attempts to cover the national field and to bring the progressive women of the provinces in touch with each other and their various activities in support of moral and social betterment. We believe there is real need and room for a publication that will do this and focus national attention on the wonderful woman's movement which is in evidence all over the world. Canada with her vast area and comparatively small population, stretching from ocean to ocean, will surely benefit by an exchange of ideas and ideals at home and from abroad."

Subscription $1.00 per year. For further information write the Editor, 87 Roncesvalles Ave., Toronto.

The report of the official proceedings of the International Council of Nurses at the Cologne Congress may be ordered from the Treasurer, International Council of Nurses, 431 Oxford St., London, W., England. Price, 6d.; postage 1d.

The catalogue of the Medical Publications of The Macmillan Company of Canada, Ltd., is small but compact and comprehensive, giving a full list of medical books with particulars of authors' standing, price and date of publication of last edition.

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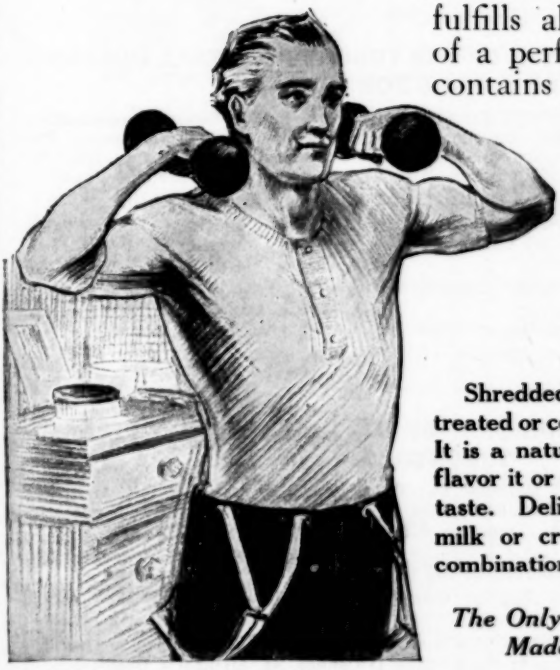

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